STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155162	A. BUILDING	01	11/15/2012
		.00.02	B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		ASHINGTON AVE	
AUTUMN	I RIDGE REHABIL	ITATION CENTRE		ASH, IN 46992	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL P. I. S.C. IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
K0000	REGULATORY O	R LSC IDENTIFYING INFORMATION)	IAG	BETTELEXCTY	DATE
10000					
	A Life Safety C	Code Recertification,	K0000		
	State Licensur				
		Ik-thru Survey were			
		the Indiana State			
	Department of				
	I	th 42 CFR 483.70(a).			
	accordance wi	12 611 103.7 0(4).			
	Survey Date:	11/15/12			
	Facility Numb	er: 000081			
	Provider Num	ber: 155162			
	AIM Number:	100289570			
	_ =	y Kelley, Life Safety			
	Code Specialis	st			
	At this Life Sa	fety Code survey,			
	Autumn Ridge	Rehabilitation			
	Centre was fo	und not in			
	compliance wi	th Requirements for			
	Participation i	n			
	Medicare/Med	licaid, 42 CFR			
	Subpart 483.7	'0(a), Life Safety			
	from Fire and	the 2000 edition of			
	the National F	ire Protection			
	Association (N	IFPA) 101, Life Safety			
	Code (LSC), CI	napter 19, Existing			
	Health Care O	ccupancies and 410			
	IAC 16.2.				
	This three sto	ry facility was			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000081

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155162	B. WIN	IG		11/15/	2012
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					SHINGTON AVE		
AUTUMN	I RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		be of Type II (111)					
	construction and was fully						
	sprinklered ex	cept as noted at					
	K-56. The fac	ility has a fire alarm					
	system with sn	noke detection in					
	corridors, area	s open to the					
	corridor and ha	ard wired smoke					
	detectors in re	sident rooms 301 to					
	306 and 324 to	o 326. The					
	remaining resident rooms had						
	battery operated smoke detectors.						
	The facility has	s a capacity of 100					
	and had a cens	sus of 57 at the time					
	of this survey.						
	,						
	The facility was	s found not in					
	compliance wit						
	· ·	ıkler coverage. The					
		ınd in compliance					
	· ·	in regard to smoke					
	detector covera						
	detector covers	uyc.					
	All areas where	e the residents have					
	customary acco						
	· ·						
	sprinklered, ex	•					
		where the laundry					
		d on the second and					
		d the computer					
		the conference					
	room. All areas providing facility services were sprinklered, except						
	two detached s						
	storage of mai	ntenance parts and					
	<u> </u>						ı

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Event ID: 8D9421

Facility ID: 000081

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	LDING	NSTRUCTION 01	(X3) DATE : COMPL 11/15/	ETED
	ROVIDER OR SUPPLIER		600 WA	DDRESS, CITY, STATE, ZIP CODE SHINGTON AVE H, IN 46992		
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	equipment and decorations.	l Christmas				
		Robert Booher, Life Safety dical Surveyor on 11/21/12.				
	The facility was	th the				
	aforementione requirements a following:	d regulatory as evidenced by the				

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Event ID: 8D9421

Facility ID: 000081

If continuation sheet Page 3 of 20

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	01	COMPL	ETED
		155162	B. WIN			11/15/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ASHINGTON AVE		
	I RIDGE REHABILI	TATION CENTRE			SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0029 SS=D	NFPA 101 LIFE SAFETY CO One hour fire rate hour fire-rated do automatic fire ext accordance with a protects hazardor approved automa system option is a separated from or resisting partitions self-closing and in protective plates a inches from the b permitted. 19.3 Based on obser interview, the fi ensure the corr second floor st combustibles, square feet in s with a self clos deficient practi resident care a staff. Findings include Based on obser Maintenance D 11/15/12 at 2: corridor door t 224, measuring size, lacked a s The room was	ed construction (with ¾ ors) or an approved inguishing system in 8.4.1 and/or 19.3.5.4 us areas. When the stic fire extinguishing used, the areas are ther spaces by smoke and doors. Doors are con-rated or field-applied that do not exceed 48 ottom of the door are 6.2.1 evation and facility failed to cridor door to 1 of 1 corage rooms with measuring over 50 size was provided ing device. This ice was not in a rea but could affect de: Evation with the irector on 103 p.m., the oresident room 1286 square feet in self closing device.	K00	TAG (29)	This Plan of Correction constitutes the written allegation of compliance for the deficience cited. However, submission of this Plan of Correction is not a admission that a deficiency ex or that one was cited correctly. This Plan of Correction is submitted to meet requirement established by state and feder law. Autumn Ridge Rehabilitation Centre desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on December 7, 2012	ies n ists ts al	12/07/2012

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Event ID: 8D9421

Facility ID: 000081

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155162	B. WING		11/15/2012
NAME OF F	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE	
AUTUMN	I RIDGE REHABILI	ITATION CENTRE		ASHINGTON AVE SH, IN 46992	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	<u> </u>	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	combustible st	torage such as 20			
	plastic totes of	f medical records			
	and two cardb	oard boxes of			
	activity supplie				
	<u> </u>	the Maintenance			
	Director at the	time of		What corrective action will be	
	observation.			done by the facility?	
	3.1-19(b)			A facility inspection was	
	3.1 13(8)			implemented and no further	
				deficiencies were noted. A self-closing device was added	to
				the door to resident room 224	
				November 26, 2012.	
				How will the facility identify oth	ner
				residents having the potential	
				be affected by the same pract	
				and what corrective action will taken?	<u>be</u>
				No residents were affecte	ad
				THO TOSIGETIES WELL ATTECHE	,
				What measures will be pr	<u>ut</u>
				into place to ensure this	
				practice does not recur?	
				- The Maintenance Directo	ur.
				or designee will make	"
				routine inspection audits	
				(see attachment A) one	
				time each week for two	
				weeks then monthly for to	wo
				months then quarterly	
				thereafter of all rooms in	
				the facility to ensure the	

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 $\label{eq:local_problem} \mbox{If continuation sheet} \qquad \mbox{Page 5 of 20}$

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	OF CORRECTION	IDENTIFICATION NUMBER: 155162	A. BUILDING B. WING	01 	COMPLETED 11/15/2012		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				presence of door closures on doors to which resider have customary access a doors to storage rooms containing combustibles to ensure compliance. How will corrective action be monitored to ensure the deficient practice does not recur and whe QA will be put into place? The Maintenance Supervisor or designee were port finding to Executive Director or designee for review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. In the event any non-compliance is noted, an action plan we be developed to ensure compliance. Date of Compliance: 12/07/12	ents and to ent nat		

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Event ID: 8D9421

Facility ID: 000081

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155162		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/15/2012		
	PROVIDER OR SUPPLIER		•	600 WA	ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0046 SS=F	duration is provid 19.2.9.1. Based on obsei interview, the f	ng of at least 1½ hour ed in accordance with 7.9. evation and facility failed to	K00)46	What corrective action will be done by the facility?		12/07/2012
	fixtures of at led duration was to annually in acc 7.9. LSC 7.9.3 Emergency Light requires requires shall be condu- required batter emergency light	ested monthly and ordance with LSC Periodic Testing of ording Equipment es a functional test ordered			A preventative maintenar audit tool has been initiat (see attachment B) to ensure emergency light fixtures of at least 1.5 hor duration are tested month and annually.	ed ur	
	conducted on a battery powere lighting system 1½ hour dura shall be fully o duration of the records of visu tests shall be k for inspection having jurisdic NFPA 110, Section	d emergency of for not less than a tion. Equipment perational for the test. Written al inspections and ept by the owner by the authority tion. In addition, cion 5-3.1 requires y Power Supply)			How will the facility identify oth residents having the potential be affected by the same practiand what corrective action will taken? No residents have been affect all residents have the potential have been affected. A written record of visual inspections and tests was put the facility preventative maintenance-monitoring log. What measures will be put into place to ensure this practice do not recur?	to ice be ed; I to	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155162	B. WIN	G		11/15/2012
	PROVIDER OR SUPPLIER			600 WA	ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	practice could	affect all occupants.			The Maintenance Directo	r
		•			or designee will complete	
	Findings includ	de:			preventative maintenance	e
					audit tool (see attachmen	t
	 Rased on an ol	oservation with the			B) completing a functiona	ıl
	Maintenance Director on 11/15/12 at 3:15 p.m., a battery operated emergency task light was				test on every required	
					battery powered emerger	ncy
					lighting system at 30 day	
					intervals for a minimum o	f
	observed at the emergency generator. Based on an interview with the Maintenance Director				30 seconds. An annual te	
					shall be conducted to the	
		review at 12:53			battery powered emerger	•
	_				lighting system for not les	ss
	•	s no written record			that 1.5 hours duration.	
		unction test or an				
	annual test for	·				
	_ ·	gency task light				
	available for re	eview.			How will corrective action be	
					monitored to ensure the deficie	
	3.1-19(b)				practice does not recur and wh	<u>nat</u>
					QA will be put into place?	
					The Maintenance	
					Supervisor or designee w	rill
					provide the results of eac	
					audit and review the	
					preventative maintenance	e
					log with the Executive	
					Director or designee upor	n
					completion. The Executiv	e
					Director will forward the	
					results to the Safety	
					Committee for further	
					review and	
					recommendation. In the	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/15/2012
AUTUMN		ITATION CENTRE	600 W	ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				event any non-compliant is noted, an action plant be developed to ensure compliance.	
				Date of Compliance: 12/07/12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155162	B. WIN	G		11/15/	2012
	PROVIDER OR SUPPLIER			600 WA	ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056 SS=E	installed in accord Standard for the Systems, to provide all portions of the properly maintain NFPA 25, Standar Testing, and Mair Fire Protection Sysupervised. There water supply for the sprinkler systems flow and tamper selectrically connected alarm system. Based on observite and the conference of 2 small en laundry chute is second and this conference root closets in account 13, Standard for Sprinkler Systems complete cover of the building practice could floor residents and as second and the second and this conference root closets in account 13, Standard for Sprinkler Systems complete cover of the building practice could floor residents and as second and the second and this conference root closets in account 13, Standard for Sprinkler Systems complete cover of the building practice could floor residents and as second and the second and this conference root closets in account 13, Standard for Sprinkler Systems complete cover of the building practice could floor residents and as second and the sec	omatic sprinkler system, it is dance with NFPA 13, Installation of Sprinkler ide complete coverage for building. The system is led in accordance with and for the Inspection, Intenance of Water-Based systems. It is fully re is a reliable, adequate the system. Required are equipped with water switches, which are exted to the building fire 19.3.5 rivation and facility failed to lete automatic is located on the reliable of the is located on the reliable of the Installation of ms, to provide rage for all portions. This deficient affect all 23 second any residents in the own with a seating residents.	K00	056	What corrective action will be done by the facility? Sprinkler heads have been installed to the computer stora room closet and both the seco and third floor laundry chute closets. How will the facility identify oth residents having the potential be affected by the same praction and what corrective action will taken? A facility inspection was implemented and no further deficiencies were noted. Sprinkler heads have been outfitted to the computer stora room closet and both the seco and third floor laundry chute closets.	ge nd er to ce be	12/07/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			COMPLETED
		155162	B. WIN			11/15/2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	L		600 WA	ASHINGTON AVE	
AUTUMN	I RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN 46992	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
					What measures will be pu	<u>ıt</u>
	Based on an ob	servations with the			into place to ensure this	
	Maintenance D	irector on			practice does not recur?	
	 11/15/12 from	n 1:31 p.m. to 2:44				
		nd and third floor			The Maintenance Supervisor of	of
	small enclosur				designee will make routine	,
					inspection audits (see attachm	
		s located and the			C) one time each week for two weeks then monthly for two	
		m computer room			months then quarterly thereaft	er
	closet lacked s	prinkler coverage.			to ensure compliance is met.	
	This was ackno	owledged by the			,	
	Maintenance D	irector at the time			-	
	of observation:	S.			- What measures will be put into)
					place to ensure this practice de	
	3.1-19(b)				not recur?	
					_	
	3.1-19(ff)				The Maintenance	
					Supervisor or designee w	/ill
					report finding to Executive	e
					Director or designee for	
					review. The Executive	
					Director will forward the	
					results to the Safety	
					Committee for further	
					review and	
					recommendation. In the	
					event any non-complianc	
					· · · · · · · · · · · · · · · · · · ·	
					is noted, an action plan w	"
					be developed to ensure	
					compliance.	
					Date of Compliance:	
					12/07/12	
					12/0//12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155162	A. BUI	LDING	01	11/15/	
		155102	B. WIN			11/15/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE		
AUTUMN	I RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG K0062	NFPA 101	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE I
SS=D	LIFE SAFETY CO	DDF STANDARD					
00-D	Required automa	tic sprinkler systems are					
		ntained in reliable operating inspected and tested					
		7.7.6, 4.6.12, NFPA 13,					
	NFPA 25, 9.7.5						
	Based on obse	rvation and	K00)62	What corrective action will be	-	12/07/2012
	interview, the f	acility failed to			done by the facility?		
	ensure cubicle	curtains installed in			The shower curtains in the thi	rd	
	1 of 1 third flo	or shower rooms			floor shower room have been		
	were in accorda	ance with NFPA 13,			replace with shower curtains was a ½ inch diagonal mesh top p		
	Standard for th	e Installation of			that extends 18 inches below		
	Sprinkler Syste	ms. Because of the			sprinkler deflector.		
	lack of cubicle	curtain and					
	sprinkler locati	on coordination			How will the facility identify other		
	which may obs	truct the sprinkler			residents having the potential be affected by the same pract		
	spray onto the	fire or may shield			and what corrective action wil		
	the heat from t	he sprinkler, this			taken?		
	deficient practi				No residents were affected.		
	three residents	in the third floor			Three residents had the poter	itial	
	shower room.				to have been affected by this		
					practice.		
	Findings includ	le:			The shower curtains in the	ie.	
	Dagad an elec				third floor shower room	-	
		vation with the			were replaced with show	er	
	Maintenance D				curtains with a ½ inch		
		24 p.m., two of			diagonal mesh top panel		
		urtains in the third			that extends 18 inches		
		oom lacked 1/2 inch			below the sprinkler defle	ctor	
		or a 70 percent			disallowing the shower		
	· ·	panel extending			curtain to obstruct the		
	18 inches belo	•			sprinkler spray.		
		was acknowledged			What measures will be p	<u>ut_</u>	
	by the Mainten	ance Director at the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUII	DING	01	COMPL	ETED	
		155162	A. BUII B. WIN			11/15/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R					
ALITIINAN	I DIDOE DELIADII I	ITATION CENTRE			ASHINGTON AVE		
AUTUMIN	I RIDGE REHABILI	ITATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	time of observ	ration			into place to ensure this		
		acion.			practice does not recur?		
					practice does not recar:		
	3.1-19(b)				- The Maintenance Companies of		
					The Maintenance Supervisor of designee will make routine)I	
					inspection audits (see attachm	ont	
					D) of facility one time each we		
					for two weeks then monthly for		
					two months then quarterly	•	
					thereafter to ensure compliance	e	
					is met.		
					⁻		
					- What measures will be put into	1	
					place to ensure this practice d		
					not recur?		
					The Maintenance		
					Supervisor or designee w	/ill	
					report finding to Executive	E	
					Director or designee for		
					review. The Executive		
					Director will forward the		
					results to the Safety		
					Committee for further		
					review and		
					recommendation. In the		
					event any non-complianc		
					is noted, an action plan w	/ill	
					be developed to ensure		
					compliance.		
					·		
					Date of Compliance:		
					12/07/12		
					-		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155162	B. WING			11/15/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			600 WA	SHINGTON AVE		
AUTUMN RIDGE REHABILITATION CENTRE				WABAS	SH, IN 46992		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0076	NFPA 101						
SS=E	LIFE SAFETY CO	·					
		ge and administration ed in accordance with					
	•	rds for Health Care					
	Facilities.	ndo for Freditir Gare					
		ge locations of greater than					
		nclosed by a one-hour					
	separation.						
	(b) Logations for (supply systems of greater					
		are vented to the outside.					
	NFPA 99 4.3.1.1.						
	1. Based on ob		K00	76	What corrective action will be		12/07/2012
	interview, the f				done by the facility?		
		gen cylinders were			-		
		•			All "E" and "H" cylinder		
	properly restra				compressed oxygen tanks have been removed from the facility		
	oxygen storage	-			combustible materials have be		
	rooms. NFPA 9				removed from the oxygen stora		
		equires cylinder			rooms.		
	restraint to me	et the requirements					
	of Section 4-3.	5.2.1(b)27 which			How will the facility identify oth residents having the potential to		
	requires freesta	anding cylinders to			be affected by the same practi		
	be chained or s	supported in a			and what corrective action will be		
	cylinder stand	• •			taken?		
	•	ce could affect 15			 		
	•	dents. The second			No residents have been affected fifteen residents had the noten	•	
					fifteen residents had the poten to have been affected.	uai	
	· ·	corage room was			to have been anotted.		
		sed unit but this			All "E" and "H" cylinder		
		ce could affect any			compressed oxygen tanks hav		
	number of staf	t.			been removed from the facility		
					combustible materials have be		
	Findings includ	le:			removed from the oxygen stora rooms.	ay c	
	Based on an ob	servations with the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED	
		155162	B. WIN			11/15/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8	600 WASHINGTON AVE				
	I RIDGE REHABILI	TATION CENTRE			SH, IN 46992	,	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	·	DATE	
	Maintenance D	irector on			What measures will be pu	<u>it</u>	
	11/15/12 from	n 1:05 p.m. to 1:50			into place to ensure this		
	p.m., there was	s an unsupported			practice does not recur?		
	"E" cylinder of	compressed oxygen				_	
	in the third floo	or oxygen			The Maintenance Supervisor of	ot	
		illing room and four			designee will make routine inspection audits (see attachm	ent	
	"H" cylinders o	-			E) of facility one time each we		
	-	ported in the second			for two weeks then monthly for		
	'•	torage/transfilling			two months then quarterly		
		is acknowledged by			thereafter to ensure compliance	e	
		- ·			is met.		
	the Maintenance Director at the				-		
	time of observa	ations.			-		
					-		
	3.1-19(b)				-		
					What measures will be put into	<u>) </u>	
	2. Based on ol	oservation and			place to ensure this practice de	<u>oes</u>	
	interview, the f	facility failed to			not recur?		
	ensure combus	stible materials			- The Maintenance Supervisor of	nr.	
	were separated	l from oxygen			designee will report finding to		
	storage equipn	· ·			Executive Director or designee	e for	
		e areas. NFPA 99,			review. The Executive Director		
	the Standard fo				will forward the results to the		
		on 8-3.1.11.2(c)2			Safety Committee for further review and recommendation. I	n	
					the event any non-compliance		
	·	ring gases such as			noted, an action plan will be		
		e separated from			developed to ensure complian		
	combustibles b				Date of Compliance: 12/07/20	12	
	distance of five	•					
	sprinklered bui						
		ice affects residents					
	15 third floor r	esidents.					
	Findings includ	de:					
	I		- [

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 11/15/2012	
	NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE		STREET A	ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Maintenance D 11/15/12 at 1 combustible m cardboard box within three fe liquid oxygen "E" cylinder of in the third flo room. This wa	:06 p.m., naterial such as les were stored et of stationary containers and an compressed oxygen or oxygen storage as acknowledged by ce Director at the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 01			COMPLETED	
		155162	B. WING			11/15/2012	
			Б. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				ASHINGTON AVE		
AUTUMN RIDGE REHABILITATION CENTRE			WABASH, IN 46992				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		ON
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
K0144 SS=F	exercised under l	spected weekly and oad for 30 minutes per nce with NFPA 99.	K01	44	What corrective action will be	12/07/20)12
		acility failed ensure			done by the facility?		12/07/2012
		acinty raned ensure					
	_	, •			The process for which the		
	<u>-</u>	nts for transferring			Maintenance Supervisor utilize to transfer power from the mai		
	•	e main source to the			source to the emergency	<u>''</u>	
		nerator. LSC 7.9.2.3			generator has been clarified a	<u>nd</u>	
	and NFPA 99, H				now meets the requirement.		
		1.1.8 requires the					
	generator set(s) shall have			How will the facility identify oth residents having the potential		
	sufficient capa	city to pick up the			be affected by the same practi		
	load and meet	the minimum			and what corrective action will		
	frequency and	voltage stability			taken?		
	requirements o	of the emergency			-		
	system within	10 seconds after			- No residents have been affect	ed:	
	loss of normal	power. This			all residents had the potential		
	deficient practi	•			have been affected		
	occupants				The necessity of the second		
	Findings includ	le:			The process for which the Maintenance Supervisor utilize to transfer power from the mai source to the emergency	n	
	Based on review	w of the "Weekly			generator has been clarified an now meets the requirement.	ıa	
		nly Load Test Log"			now meets the requirement.		
	· ·	enance Director on			What measures will be pu	ıt İ	
	11/15/12 at 12				into place to ensure this		
	· · · ·	est record indicated			practice does not recur?		
	<u> </u>	power from the			<u> </u>		
		•			- The Maintenance Directo	r	
		the emergency			or designee will complete		
	generator took	rrom 22 to 28			preventative maintenance		

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	OF CORRECTION OF CORRECTION 155162	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 11/15/2012		
	PROVIDER OR SUPPLIER N RIDGE REHABILITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	seconds for the previous 10 months of 2012. This was confirmed by the Maintenance Director at the time of record review. 3.1–19(b)		audit tool (see attachmer G) completing a functional test transferring power from the main source to the emergency system within 10 seconds one time each week for two weeks then monthly for two months then quarterly thereafter. - What measures will be put integrated to ensure this practice of not recur? - The Maintenance Supervisor of designee will report finding to Executive Director or designer review. The Executive Director will forward the results to the Safety Committee for further review and recommendation. The event any non-compliance noted, an action plan will be developed to ensure compliance noted, an action plan will be developed to ensure compliance. Date of Compliance: 12/07/12 NFPA 101 LIFE SAFETY COLUMBER.	al om n ch ch or e for r ln e is nce.		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 11/15/2012			
	NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				Yes No COMPLETE FUNCTION TEST TRANSFERRING POWER FROM THE MA SOURCE TO THE GENERATOR WITHIN A SECONDS COMMENTS:	AIN			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE S COMPLI 11/15/	ETED
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
	RIDGE REHABILI		WABAS	SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE
				Reviewed by Executive Director: Signature/Date Follow up required:		

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